**STATE OF CALIFORNIA**
**DEPARTMENT OF INSURANCE**
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# REVISED FINAL STATEMENT OF REASONS
# Health Care Language Assistance Program Regulations

The Final Statement of Reasons, OAL File# 06-1130-03 S dated November 27, 2006, is incorporated by reference herein and supplemented as follows:

## *AUTHORITY*

Insurance Code section 10133.8 requires the Commissioner to develop and adopt regulations by January 1, 2006, to establish standards and requirements to provide insureds with appropriate access to translated materials and language assistance in obtaining covered benefits.

## *NECESSITY*

SB 853 (2004) added Chapter 2.2, sections 10133.8 and 10133.9 to the Insurance Code expressly instruction the Commissioner to develop and adopt regulations by January 1, 2006. The statute also contained specific requirements for the content of the regulations, including requirements that the regulations establish the standards and requirements for insurers' provision of translation and interpretation services. Accordingly, the regulation establishes standards and requirements related to: assessing the linguistic needs of insureds; arranging for and providing translation and interpretation services; training insurer staff; and monitoring compliance with the regulation.

## *SPECIFIC PURPOSE OF THE REGULATION*

The regulations are reasonably necessary to provide insurers with clear, detailed information and instructions regarding the development and implementation of a language assistance program (LAP), their monitoring and evaluation responsibilities, and the Insurance Commissioner's authority to assess and evaluate their performance and impose fines and penalties. Throughout the regulations, significant portions of Insurance Code sections 10133.8 and 10133.9 are duplicated. This is necessary due to the complexity of the statute and the details that must be accounted for by health insurers as they develop their LAP. The duplication is necessary for the sake of efficiency, to provide clarity, and to address the concerns of the regulated public (health insurers) who requested that the regulations be able to serve as a "stand-alone" document. This will provide health insurers with all the information needed to develop and implement a language assistance program in compliance with the statute and these regulations without having to refer back to the statute. Several health insurers also work in the HMO market and therefore are working with both DMHC and Department of Insurance to implement these statutes. Including all information needed for health insurers to fully implement these regulations in one document is much more user friendly and will increase the likelihood that implementation will take place with reduced problems, concerns, questions and delays.

**Section 2538.1 AUTHORITY AND PURPOSE**

This section is necessary to inform affected persons and insurers of the purpose of the regulations and to whom the regulations apply. This section provides a reference to the section of the Insurance Code that defines "health insurer" for the purposes of these regulations.

**Section 2538.2 DEFINITIONS**

This section is necessary to define and clarify the special terms referenced in the regulation and inform insurers and other affected persons of the specific meaning of various requirements. Although many of the words and terms defined have a generally understood meaning in the insurance industry, definitions of certain words and terms are included to avoid any ambiguity or uncertainty in the application of the regulations. Certain of the definitions are used to encompass concepts that may not be readily apparent from the word or term used. The definition of demographic profile, for example, is specific enough to provide insurers with the exact information that is required to be obtained from insureds.

**Section 2538.3 LANGUAGE ASSISTANCE PROGRAM**

In response to public comments, subsection (a) has been modified to push back the date for implementation of the LAP. This is necessary to inform the regulated public of the date by which the language assistance program must be established and implemented. The implementation date has been determined through consultation with internal experts, health insurers and consumers. It conforms to the requirements of the statute that the health insurers have one year from the effective date of these regulations to conduct their needs assessment and sets the minimum time determined reasonable for insurers to establish and implement the Language Assistance Program. This subsection is also necessary to take into account, as permitted by Insurance Code section 10133.8(c)(9), the Commissioner's recognition of the need for insurers to have flexibility in the methods they use to achieve compliance with the regulation.

In response to public comments, subsection (b) had been revised to provide more clarity regarding the contents of the LAP plan. It is necessary to inform the regulated public of the elements that must apply in the development and implementation of its language assistance program, including the standards and requirements expressly required by sections 10133.8 and 10133.9. It establishes that the language assistance program plan must specify, at a minimum, the "who, what, when, where and how" of their language assistance program. This subsection restates for the purpose of clarity for insurers, the key elements of the LAP as defined in the statute: assessment of language needs of insureds, arranging for and providing language assistance services, training insurer staff, and monitoring compliance.

In order to provide additional guidance, as requested by insurers, this subsection also details some of the key elements that must be included in the LAP. These elements were determined in consultation with Department staff who will be reviewing the LAP plans and who conduct market conduct surveys of insurer compliance activities as well as through stakeholder group meetings and input from the Department of Managed Health Care. This subsection has been amended to clarify that the policies and procedures must include at least the four key components listed and must provide details as described in the seven listed elements. These details are necessary for the Department to obtain enough information from each health insurer to determine compliance with the statutory requirements of SB 853 and provide the required data for reporting to the Legislature.

In response to public comments, subsection (c) has been revised and reformatted to provide clarity regarding the notice requirements of the statute and the procedure to follow if the Commissioner develops a notice and if he does not. This subsection is necessary to inform the regulated public of the details of providing the notice of language assistance services to insureds. Insurers provide a multitude of documents and mailings to their insureds making it necessary for the Commissioner to identify those particular documents and mailings in which the notice must be included. Lack of specificity here would result in an extremely burdensome requirement on insurers. This subsection has been amended to clarify the statutory requirement that notice be provide to insured respecting two distinct issues: availability of translated vital documents in the threshold languages identified through the needs assessment/survey and availability of oral interpreter services in the requested language of the insured.

While health insurers are given wide latitude in how they develop this notice these two elements must be included. Furthermore, the Commissioner may develop the key components of the notice in which case insurers shall use this notice form as the basis for their notice. This will provide the requested consistency in the core contents of the notice as requested by consumer groups around the state. Insurers however, will include in the notice their particular insurer specific information such as what phone number to call to request translated documents or an individual interpreter. If a core notice form is developed by the Commissioner, the insurer must incorporate this as part of their notice to insureds. If the Commissioner does not develop a notice, this subsection clarifies that the insurer shall be responsible for its development.

Subsection (d) is necessary to clarify that sections 10133.8 and 10133.9 impose on health insurers, not on contracting providers or networks, the obligation to establish a language assistance program and to provide or arrange for the provision of language assistance services. This section duplicates several provisions from the statute for the sake of efficiency, to provide clarity, and address the concerns of the regulated public, health insurers, who requested that the regulations developed serve as a "stand-alone" document. This will provide health insurers with all the information needed to develop and implement a language assistance program in compliance with the statute and these regulations without having to refer back to the statute. The Commissioner is keenly aware that the provision of language assistance services as required by sections 10133.8 and 10133.9 will have a cost impact.

This subsection specifies and clarifies that the statute directs the Commissioner to require health insurers, not providers, to develop a LAP plan that will ensure the provision of translation and interpretation services to insureds in accessing their health care. No insurer has communicated to the Commissioner a contrary perspective. Section 10133.8 does not prohibit insurers from appropriately and fairly delegating this responsibility to contracting provider, groups, or networks. An insurer's delegation of any or all of its responsibility to provide language assistance services must be pursuant to a written contract that specifies the services to be provided by the insurers delegatee. However, health insurers retain ultimate responsibility for ensuring that their insureds receive both interpretation services in the receipt of their health care and translated vital documents.

In response to public comments, subsection (e) was revised to delay the date at which the LAP plan is to be filed with the Commissioner to conform to the later effective date of these regulations. Subsection (e)(2) has been revised in response to public comments to provide clarity regarding the evaluation methodologies to be used by the Commissioner as well as

deleting the consideration of cost as a factor. This factor is permitted to be considered by the insurer in the development of the plan however, there is no statutory authority to consider this factor in the evaluation of the insurers LAP plan. In developing this subsection, the regulations for SB 853 adopted by the Department of Managed Health Care in Title 28 CCR, section 1300.67.04 have been reviewed and modified to meet the unique needs of health insurers to assure that insureds receiving health care through a health insurer (Department of Insurance) receive the same language assistance services as an enrollee receiving health care through an HMO (Department of Managed Health Care).

It is necessary to provide guidance to the regulated public regarding the data insurers must provide to the Commissioner for review as well as establish the date for health insurers to file their LAP plan with the Commissioner. This date has been determined in consultation with stakeholders and internal experts to allow a reasonable time from the statutorily determined deadline for completion of the needs assessment. The deadline in this subsection is intended to be the latest date by which health insurers must develop and submit the language assistance program plan as required by sections 10133.8 and 10133.9. Subsection (e)(2) specifies the factors that the Commissioner will use to evaluate the insurer's LAP. This subsection is necessary to provide clarity and specificity to insurers regarding how and on what basis their LAP plan will be evaluated. Subsection (e)(3) describes the methodologies the Commissioner will use to evaluate the insurers LAP plan. The methodologies were determined by consultation with Department staff responsible for insurer evaluation and compliance. This subsection also provides the Commissioner authority to request the necessary information from insurers in order to meet the statutory reporting requirements to the Legislature.

**Section 2538.4 NEEDS ASSESSMENT OF INSURED POPULATION**

This section is necessary to comply with the express requirements of section 10133.8(b)(1) that insurers conduct a needs assessment of their insureds by surveying the language preferences and assessing the linguistic needs of their insureds. This section is also necessary to comply with the requirement to determine the threshold languages into which specified documents must be translated. Significant portions of Insurance Code sections 10133.8 and 10133.9 are duplicated herein due to the complexity of the statute and the details that must be accounted for by health insurers as they develop their LAP. The duplication is necessary for the sake of efficiency, to provide clarity, and address the concerns of the regulated public, health insurers, who requested that the regulations developed serve as a "stand-alone" document. This will provide health insurers with all the information needed to develop and implement a language assistance program in compliance with the statute and these regulations without having to refer back to the statute.

**Section 2538.5 WRITTEN TRANSLATION OF VITAL DOCUMENTS**

This section is necessary to define the exact methodology to be used by insurers to determine and identify the languages into which specified documents must be translated. It includes significant portions of Insurance Code sections 10133.8 which are necessary due to the complexity of the statute and the details that must be accounted for by health insurers as they develop their LAP. The duplication is necessary for the sake of efficiency, to provide clarity, and address the concerns of the regulated public, health insurers, who requested that the regulations developed serve as a "stand-alone" document. This will provide health insurers with all the information needed to develop and implement a language assistance program in compliance with the statute and these regulations without having to refer back to the statute.

Subsection (c) as been revised in response to public comments to allow the request to phase-in the translation of public documents to be included with the submittal of the LAP plan. This will allow insurers to complete the needs assessment in order to determine if phase-in of the translation of vital documents is required. This subsection is necessary to provide a specific timeframe and requirements for insurers to request phase-in of the implementation of translation of vital documents.

Subsection (d) is necessary to inform the regulated public that the insurer shall monitor the quality and accuracy of translated documents as well as proficiency of the translators.

**Section 2538.6 INDIVIDUAL ACCESS TO ORAL INTERPRETATION SERVICES**

This section is necessary to provide the basic standards and expectations regarding an insurer's provision of interpretation services to insureds. The underlying statute does not impose any limitation on the number of languages that should be available through interpretative services. The regulation similarly reflects that access to interpretative services must be provided for all languages where language assistance is needed by an insured. This section is also necessary to provide the range of interpretation services that may be provided by an insurer to an insured.

Subsection (c) is necessary to provide the parameters for using minors as interpreters in health care settings including emergency and non-emergency situations. This issue was hotly debated by stakeholders who acknowledged that it was necessary for the regulations to set out the parameters regarding the use of a minor as an interpreter in a health care setting. The specific parameters detailed in the regulation were drawn from documentation received and public comments submitted by consumer groups and insurer organizations during the rulemaking process. They address a variety of situations that occur with regularity for LEP insureds. The regulation is drafted to provide a middle ground between the concerns of LEP consumers (minors should never be used as interpreters) and health insurers (LEP insureds should have free choice of interpreter, using a minor child if desired).

Subsection (d) is necessary to clarify the qualifications and proficiency of individuals providing interpretation services to insureds. The regulation was revised based on public comments regarding the problems in limiting the acceptable standards to one trade association versus the need for identifying a level of proficiency for interpreter services. The revisions clarify that certification from two recognized interpreter organizations, California Healthcare Interpreters Association and National Council on Interpreting in Health Care will be accepted by the Insurance Commissioner as meeting a proficiency standard.

**Section 2538.7 HEALTH INSURER MONITORING, EVALUATION & REPORTING**

This section is necessary to establish the requirements for an insurer's quality assurance oversight of its respective language assistance program. It clarifies the required scope of quality assurance monitoring activities, confirms the timeline for future language needs assessments, and establishes that insurers must assess and modify their language assistance programs on an ongoing basis. Significant portions of Insurance Code sections 10133.8 and 10133.9 are duplicated herein. This is necessary due to the complexity of the statute and the need to restate the statutory requirements of reporting in the regulation for the sake of efficiency, to provide clarity, and address the concerns of the regulated public, health insurers, who requested that the regulations developed serve as a "stand-alone" document. This will provide health insurers with

the information needed to monitor, evaluate and report on their LAP to remain in compliance with the statute and these regulations without having to refer back to the statute.

Based on public comments, subsection (c) has been revised to specify the information that insurers must provide to the Department so that the Department can meet its statutory reporting requirements to the Legislature. The reporting requirements are designed to require the minimum needed for the Department to meet its statutory reporting to the Legislature. It has also been revised to provide additional specificity related to the due dates for insurer reporting to the Department.

**Section 2538.8 DEPARTMENT OF INSURANCE REPORTING**

This section is necessary to implement the requirements of section 10133.8 (f) that the Department report biennially to the Legislature regarding health insurer compliance with the standards established by this section, including results of compliance audits made in conjunction with other audits and reviews. Significant portions of sections 10133.8 and 10133.9 are duplicated herein for the sake of efficiency to provide clarity to the regulated public. This will provide health insurers with the information and deadlines needed to produce the documentation needed to meet the Department's reporting requirements.

## *MATERIAL RELIED UPON*

The materials relied upon are stated in the Initial Statement of Reasons, OAL File# 06-1130-03 S, and are incorporated by reference herein.

## *LOCAL MANDATE DETERMINATION*

The determination as to whether adoption of these regulations imposes a mandate on local agencies or school districts is stated in the Notice of Proposed Action/Initial Statement of Reasons, OAL File# 06-1130-03 S, and is incorporated by reference herein.

## *REASONABLE ALTERNATIVES*

Insurance Code sections 10133.8 and 10133.9 require the Department to adopt a regulation by January 1, 2006, and mandate much of the content of this regulation. Through meetings with stakeholders and consideration of the documents listed in the Initial Statement of Reasons, many different alternative texts to this regulation were presented to and/or considered by the Department.

The Department will continue to consider information and data collected from insurers' implementation of their language assistance programs in order to file its required biennial report to the Legislature as well as to make recommendations for changes that further enhance the standards developed under this regulation.

## *ECONOMIC IMPACT ON SMALL BUSINESS*

The Commissioner has not identified any economic impact on small business from these regulations since the regulations apply solely to health insurers, who by definition are not small businesses.

## *SUMMARY AND RESPONSE TO PUBLIC COMMENTS*

On August 11, 2006, the Commissioner made available for public comment the text of the proposed regulations. Public comments from twenty organizations were received during the 45-day comment period that ended on September 26, 2006. A public hearing was held on September 26, 2006 to solicit comments from the interested public.

On October 25, 2006, the Commissioner made available for public comment certain changes to the regulation text as initially proposed. The changes were sufficiently related to the rulemaking as originally noticed such that a reasonable member of the directly affected public could have determined from the original notice that these changes could have resulted. Public comments from eleven organizations were received during the first 15-day public comment period ending November 9, 2006.

On May 17, 2007, the Commissioner made available for public comment certain changes to the regulation text as previously amended. The changes were sufficiently related to the rulemaking as originally noticed such that a reasonable member of the directly affected public could have determined from the original notice that these changes could have resulted. Public comments from twelve organizations were received during the second 15-day public comment period ending June 1, 2007.

On July 6, 2007, the Commissioner made available for public comment certain changes to the regulation text as previously amended. The changes were sufficiently related to the rulemaking as originally noticed such that a reasonable member of the directly affected public could have determined from the original notice that these changes could have resulted. Public comments from eleven organizations were received during the third 15-day public comment period ending July 23, 2007.

OAL File# 06-1130-03 S is incorporated by reference in its entirety herein and made part of this rulemaking file.